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DATE OF REVIEW: 6/16/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Lumbar CT Myelogram with contrast.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Lumbar CT Myelogram with contrast.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient has chronic low back pain with radiation into at least the right lower extremity. The injury was noted to have occurred over XX ago in XX. Diagnoses have included post laminectomy syndrome and sacroiliac sprain along with reflex sympathetic dystrophy. Her surgical history includes a L5-S1 laminectomy and discectomy in XX. She is most recently XX post insertion of spinal cord stimulator. Worse pain in the waist and buttocks that was not controlled by the spinal cord stimulator was documented on X/X/XX. There was also increased pain in the left hip. There was persistent pain and numbness into the right leg. Exam findings included an antalgic gait and sacral tenderness. Although motor power was intact there was decreased sensation at the right lateral thigh and calf. There was a positive

Faber and straight leg raise. Medications have most recently included Norco, Celebrex and the Neurontin along with Ambien. There was a consideration for a CT-Myelogram to further support additional treatment. Prior imaging studies were not provided.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

There has been no recent documentation that evidences that this individual is being considered for surgical planning. There is no evidence of a spinal fluid leak, indication for assessment of infection, poor correlation with MRI studies and/or preclusion of the individual undergoing an MRI scan. Therefore applicable guideline criteria referenced below have not been met and medical necessity has not been established at this time.

Reference: ODG Low Back Chapter

ODG Criteria for Myelography and CT Myelography:

1. Demonstration of the site of a cerebrospinal fluid leak (postlumbar puncture headache, postspinal surgery headache, rhinorrhea, or otorrhea).
2. Surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising in a given case and, if it is, can help in planning surgery.
3. Radiation therapy planning, for tumors involving the bony spine, meninges, nerve roots or spinal cord.
4. Diagnostic evaluation of spinal or basal cisternal disease, and infection involving the bony spine, intervertebral discs, meninges and surrounding soft tissues, or inflammation of the arachnoid membrane that covers the spinal cord.
5. Poor correlation of physical findings with MRI studies.
6. Use of MRI precluded because of:
 - a. Claustrophobia
 - b. Technical issues, e.g., patient size
 - c. Safety reasons, e.g., pacemaker
 - d. Surgical hardware

Indications for imaging -- Computed tomography:

- Thoracic spine trauma: equivocal or positive plain films, no neurological deficit
- Thoracic spine trauma: with neurological deficit
- Lumbar spine trauma: trauma, neurological deficit
- Lumbar spine trauma: seat belt (chance) fracture
- Myelopathy (neurological deficit related to the spinal cord), traumatic
- Myelopathy, infectious disease patient
- Evaluate pars defect not identified on plain x-rays
- Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)